

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

15096

State File No. ....

FILED MAY 31 1955

BIRTH NO. ....		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3020</u>		Registrar's No. <u>89</u>	
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, state RURAL and give township) <u>Washington</u>		c. LENGTH OF STAY (in this place) <u>1 month</u>		c. CITY OR TOWN <u>Washington</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>St. Francis Hospital</u>				f. STREET ADDRESS (If rural, give location) <u>304 West 5th St. H. 0360</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>PAULA</u> b. (Middle) <u>HOFFMANN</u> c. (Last) <u>HOFFMANN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5 25 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>May-11-1882</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Librarian</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Union Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert Hoffmann</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Stump</u>		14. NAME OF HUSBAND OR WIFE <u>Single</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no unknown) <u>No</u> (If yes, war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>443-36-0926</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Robert Hoffmann</u> ADDRESS <u>Washington, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>age</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>				INTERVAL BETWEEN ONSET AND DEATH <u>April 24 - May 24 1955</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 24</u> , 19 <u>55</u> , to <u>May 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>55</u> , and that death occurred at <u>1:00 PM.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>L. O. Miller M.D.</u>		23b. ADDRESS <u>905 Elm Washington Mo.</u>		23c. DATE SIGNED <u>May 24, 1955</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-27-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Old Willow Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Washington Missouri</u>	
DATE REC'D BY LOCAL REG. <u>5/27/55</u>		REGISTRAR'S SIGNATURE <u>H. J. Hudson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. H. Byrd</u>		ADDRESS <u>Washington, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 14 1955

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### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 45

P. O. Address Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.